MEDICAID BULLETIN

North Dakota Department of Human Services
Medical Services Division
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Bismarck, ND 58505-0261

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Issue 55 **January 2004**

PLEASE ROUTE TO BILLING CLERKS, INSURANCE PROCESSORS, SCHEDULERS AND OTHER APPROPRIATE MEDICAL PERSONNEL. PLEASE MAKE COPIES AS NEEDED.

Release of Information on Minor Children

Except for treatment for sexually transmitted diseases (STD) or treatment for alcohol and drug abuse of a minor age 14 or older (and treatment in the case of an emergency), the parent or legal guardian of a minor is the minor's personal representative and has a right to receive information regarding the treatment or payment for treatment regarding the minor child. Under North Dakota law, unless otherwise agreed (or unless the STD or drug abuse exception applies), -- a covered entity must disclose protected health information to the parents or legal guardian of a minor -- an individual under the age of 18.

Release of Third Party information

Health care providers MAY disclose third party information (from another provider) UNLESS drug/alcohol treatment is involved. This is a shift in practice for medical record personnel. Prior to implementation of the Health Insurance Portability and Accountability Act (HIPAA), providers only disclosed information it created. Prior to HIPAA another provider's information was not re-disclosed. However, HIPAA Privacy Rules define Health Information as " any information, whether oral or recorded in any form or medium that:

1. Is created or ***received*** by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and

2. Relates to the past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual."

Patients/clients do have the right to restrict disclosures; therefore, if someone has exercised that right, and the provider accepted the restriction, it would be possible that a provider would not be able to disclose certain information, which could include third party information. Because of exceptions, providers may have implemented or continued with former policies of re-disclosure. In doing so, the patient's right to allowing disclosure of all health care information could be compromised.

Notice to Optometric Providers

If you have submitted a prior authorization request to Dr. Mitchell and have not received a reply within 2 weeks, please call him to confirm the request was received.

Name change for the Medicaid Lock-In Program

The Medicaid Lock-In Program is now the ***Coordinated Services Program (CSP).*** The name became official on January 1, 2004.

Purpose: The name change is to eliminate any misunderstanding as to the purpose of the program.

The Term Lock-in Program seems to imply negativity or is punitive in nature. Notably the Lock-In name does not express the nature of the program. The program is basically a managed care program used to educate recipients on the proper use of medical services and give guidance on how to access appropriate medical services.

This program is driven by primary care concepts and provides coordinated care, managed by one physician. With assistance from the Medicaid Agency the primary physician (CSP Physician) will be able to manage medical care with quality assurance and best outcomes.

The Surveillance and Utilization Unit monitors the patient's use of emergency room services, drug type, duration and quantities. Early refill attempts and multiple prescribing physicians are also included in the reviews. Compliance to physician treatment plans and advice are measurable criteria in reviewing a patient's medical usage.

All current reports, referral forms, selection forms and other documents will be changed to reflect the new name and will be replaced when the current supply is depleted. We will supply each CSP provider with a copy of the referral form. The referral form can be reproduced as needed.

If you have any questions or concerns related to the Coordinated Services Program, you may contact Medicaid staff at (701) 328-2334, 328-4010 or the Program Administrator at 328-4024.

CSP (Lock-In) Reminders

Referrals need to be made prior to services being received.

Backdated or retroactive referrals will not be accepted. If the referral is not received in a timely manner, documentation must be furnished before the referral can be honored.

Referrals must be physician specific and not to a hospital, clinic or Chemical Dependency Unit (CDU). Always include the first name of the referred physician.

Only the Coordinated Services Program (CSP) physician can authorize a referral.

The time frame should be specified, i.e. specific date, range of dates, or indefinite. (Specific dates are preferred where applicable.)

Although emergency services can be obtained without a referral, all emergency claims will be reviewed for compliance with standard medical practices in obtaining emergency services.

Providers should use the automated eligibility system (VERIFY SYSTEM) for information on a Medicaid patient's eligibility status, including specifics concerning involvement in the CSP Program. You may call 701-328-2891 or 800-428-4140.

Providers who wish to be removed as a CSP participating provider for a Medicaid patient are asked to send their request in writing. We also request that you continue to provide services up to 30 days from your date of notice to this office.

If a CSP patient changes his/her CSP physician, all current referrals are void. The patient will need to obtain new referrals from the new CSP physician.

It is important that all staff, i.e., appointment, reception, billing / insurance, as well as physicians, are made aware of placement of one of your Medicaid patients on the Coordinated Services Program (CSP). Your facility is notified in writing when one of your patients is placed on the CSP.

Claim Adjustment Forms

Need to file an adjusted claim? Please go to our web site to locate the form: www.state.nd.us/eforms/ # 639 Provider Request for an Adjustment.

Taking Recipient Liability (RL) at the Time of Service

With the exception of Pharmacy Point of Sale, providers are not to collect Recipient Liability at the time of service. Rather, providers are to file the claim, then collect the RL only if directed by the information on the Remittance Advice.

Here is an example of why the RL cannot be collected "upfront": A recipient goes to the dentist and the dentist collects the RL. At the end of the dental appointment, the recipient is given a prescription to fill. The recipient proceeds to the pharmacy to have the prescription filled and the pharmacy (point of sale) system shows the recipient to have RL, which they must collect at the time of service. The recipient has already paid the RL at the dentist, but the point of sale system does not reflect this and the pharmacist insists on collecting the RL. The recipient is unable to pay the RL to the pharmacist and cannot have the prescription filled.

Medicaid Coding Guideline

Updated guideline: PEGFILGRASTIM (Neulasta)

Effective for dates of service on or after January 1, 2004 utilize HCPCS code J2505 - Injection, pegfilgrastim, 6 mg (Neulasta) *subcutaneous injection, administered once per chemotherapy cycle.*

NOTE: Until January 1, 2004 utilize S0135 - Injection, Pegfilgrastim, 6 mg (Neulasta)

Check other MEDICAID CODING GUIDELINES under Medicaid Provider Information at our website: http://lnotes.state.nd.us/dhs/dhsweb/nsf/ServicePages/MedicalServices

Dental Updates

Non-intravenous conscious sedation (D9248) is considered part of the dental service/procedure performed on the same date and will not be reimbursed separately.

It is not appropriate to code and bill with other dental anesthesia code(s) (D9210-D9242) when Non-intravenous conscious sedation is administered.

Claims that Cover Two Months

Please submit claims for each month of service separately to ensure recipient liability is applied correctly. Claims received on or after February 15, 2004 that cover two months will be denied.

Third Party Liability (TPL)

Following is an update for providers on Medicaid requirements for Health Insurance, Child Support Orders and Liability Insurance issues.

Medicaid is required by Federal mandate to identify, verify and enter health insurance and other third party resources prior to paying any medical bills covered by third party payers. Medicaid has a number of edits and processes within the claim processing system to identify billings covered by third party payers. The following is an outline of those edits and processes:

1. Medicaid requires all providers to bill known third party payers prior to billing Medicaid. The claims processing system has edits that will identify bills submitted that are subject to third party coverage and return the bill to the provider if there is no third party payment indicated on the claim or Explanation of Benefits (EOB) attached.

2. Providers can verify if there is a third party payer by using the automated telephone Verify System (1-800-428-4140 or local 328-2891) The system will give eligibility, recipient liability, and TPL information. When necessary, the County Social Service Office can provide this information. The patient should be reporting coverage to the provider. The recipient may not always have the insurance card and policy information with them and the county can provide the information.

3. If the third party is unknown to the provider at the time of billing, Medicaid will deny the claim and return the billing to the provider with an EOB containing the third party billing information. If the provider is aware of third party coverage and it is not on Medicaid's files, we encourage the providers to report the third party information to the state TPL Unit, 328-4024, 3507, 4010 or 1-800-755-2604 ext. 4024.

4. Providers, under their Medicaid Agreement, accept Medicaid payment as payment in full. If there is a liability issue related to business, auto, home insurance or malpractice, the provider may bill Medicaid for timely payment. If the provider receives payment, the provider may not pursue the third party liability claim because of the double billing issue. If the provider bills Medicaid and later becomes aware of the third party liability action and wishes to pursue the payment from the

third party, Medicaid must be reimbursed before any action is taken to collect from the third party.

5. If a provider receives a payment from a third party source after receiving payment from Medicaid, the provider must reimburse Medicaid within 60 days of receipt of the payment. Medicaid can apply interest to those payments not received within 60 days after the receipt of the third party payment.

6. Medicaid eligible recipients are required to use available resources prior to billing Medicaid. If the Medicaid recipient is also in an HMO, Preferred Provider or Managed Care program, the recipient must receive services from the designated provider. If the third party payer requires prior authorization, second opinion or other criteria for benefits, the provider or recipient must meet the requirements. If the third party payer denies payment because a criterion was not met, Medicaid will deny the claim also.

7. It has been our experience that some denials can be appealed with proper documentation. Out of network claims may be paid if an emergency exists or the covered individual does not live in the geographic area with access to the network. The managed care organization in many cases will cover these claims at a lesser rate. Medicaid requires that providers make a reasonable effort to pursue these avenues of payment.

These are the basic requirements and procedures for third party payers under the Medicaid Program. If there are any additional questions and concerns, you may contact Ray Feist, Administrator of the Medicaid TPL Program at 328-4024.

Durable Medical Equipment Updates

As of January 1, 2004, all codes less than $300.00 (including L codes) will not require a prior authorization. Miscellaneous codes, rentals, and any code that is not on the price guide will still require a prior authorization along with everything else that is being provided with the same item. Please keep all prescriptions, invoices and other documentation on file for future retro-reviews. Changes in the manual that reflect this will be e-mailed to providers.

The use of ICD-9 Codes began with HIPPA compliance changes as of 10-16-2003. Our computer system, (as well as the 278's some providers may be using in the future) will accept only numerical diagnostic codes, not narrative. For this transition time use both the ICD-9 code and a narrative. Priors that have only ICD-9 Codes will be sent back.

Remember! All miscellaneous codes (examples: E1399, K0108, B9998, L2999) require an attached invoice with the acquisition cost, along with the claim, even if there is a prior authorization on the same item. Without the invoice, the claim will be denied.

Hearing Aids: As of January 1, 2004 the following changes will be made to the hearing aid dispensing requirements.

1. Hearing loss of at least 40dB at frequencies 500 Hz, 1000 Hz, and 2000 Hz (average of 40dB), **in the ear with the best hearing acuity** on all clients 18 years and older.

2. One hearing aid for all users over 18 years old. (This will include previous binaural users).

3. Recipient has not had a hearing aid provided by Medical Assistance in either ear for at least 5 years.

4. Hearing aid repairs will be reimbursed at 40% above invoice and must accompany the claim or it will be denied. Repair charges under $50.00 do not require an invoice; charges at or under this will be paid at billed amount. Repairs over $300.00 continue to need prior approval.

5. Medicaid reimbursement for a hearing aid will not exceed $350.00. The dispensing fee will remain at $350.00.

Please remind your staff that all rentals require a prior authorization.

Medicaid Managed Care

The primary care provider (PCP) program includes services that are open access and services that require a referral from the patient's individual PCP. Open access means the service can be accessed without being provided by or referred by the PCP. One of the open access services is OB/GYN service. Federal regulation requires that female enrollees must have direct access to a women's

health specialist for covered care necessary to provide routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist. North Dakota Medical Assistance considers this to include direct services provided by a physician specializing in obstetrics and/or gynecology, and services referred by the OB/GYN. To further increase access to this type of care, services provided by or referred by nurse midwives are also open access.

On the claim, if the service is directly provided by the OB/GYN or nurse midwife, their NDMA provider number must be stated in must be stated in block 24K on a CMS (formerly HCFA) 1500 or blocks 82/83 on a UB92. If the OB/GYN or nurse midwife is referring for a service that requires a referral, it must be stated in blocks 17 & 17a on a CMS (formerly HCFA) 1500 or block 83 on a UB92.

Referrals

Most North Dakota health care providers are familiar with PCP requirements. Specialty services require a referral enrollee's PCP. Currently the PCP program associates the enrollees to the chosen PCP. Therefore, a referral for specialty care must come from the PCP, not a colleague of the PCP.

Many times the claim is denied because the PCP's UPIN or provider number is not on the claim as the referring or performing physician. When this occurs, the system automatically denies the provider's claim with an EOB 38 message on the remittance advice. This message states, "services not provided or authorized by designated (network) provider." Claims with this EOB message must be resubmitted with a completed adjustment form and supported by a referral from the patient's PCP.

When the provider submits an adjustment, a copy of the referral must be attached. This is the only time a referral form needs to be sent to the state Medicaid office. Please do not attach a referral to a claim or send it under a separate cover to our office. Provider Relations staff screen all adjustments for the referral requirement.

Within the PCP program, retroactive referrals are not recognized except for extenuating circumstances. Claims associated with retroactive referrals will be subject to review and possible nonpayment. Simple negligence on the part of the enrollee or the provider to confirm the existence of a referral is not accepted.

The PCP program allows Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) to be a PCP selection. This serves providers and patients by increasing access to primary care. The VERIFY system states the name of the individual physician, RHC or FQHC. When a RHC or FQHC is a PCP, referrals for specialty care must come from the physician who supervises the facility or is associated with the facility. While nurse practitioners and physician assistants provide numerous and invaluable services in these facilities, they cannot authorize a referral. When a referral originates from a RHC or FQHC, all claims from providers of referral services must contain the Medicaid provider number or UPIN of the authorizing physician. The Medicaid provider number of the RHC, FQHC, nurse practitioner, or physician assistant cannot be used on the claim.

Do Not Submit Carbon Copies of Claims!

Medical Services CANNOT accept a carbon copy paper claim, as they will NOT go through the scanner. Carbon copy paper claims will be returned to the provider.

HIPAA Transactions Update

The N.D. Department of Human Services (DHS) has updated its contingency plan for HIPAA transaction processing. The department may likely accept claims in the old format through April 5, 2004. This date will be firm, and DHS strongly encourages all providers to test their HIPAA transactions with the department immediately. Providers who send paper claims after April 5, 2004 may experience a delay in payment, as the process is much slower than submitting electronically.

Pharmacy Prior Authorization

Last year, the 2003 Legislative Assembly passed House Bill 1430, creating a Drug Use Review (DUR) Board to advise the Department of Human Services in developing a **Prior Authorization (PA)** process to help ensure that beneficiaries receive appropriate medications in the most cost-effective manner, thus conserving state expenditures for drugs whenever possible. The pharmaceutical

benefits segment of the Medicaid budget has been increasing dramatically for several years. For the last biennium, the Department expended $106.3 million (retail drug costs) for covered beneficiaries.

The DUR Board, consisting of six physicians, six pharmacists, and 2 non-voting members of the Department and one from the Pharmaceutical Research and Manufacturers of America, has reviewed and supports the Department's plan to implement the PA process for **proton pump inhibitors** (PPIs) and antihistamines. Future memos will address additional drug classes.

Necessary programming for our system has been completed. Therefore, the Department has been able to select a launch date for our prior authorization program.

Due to our desire to give providers and recipients sufficient notice, the launch date for Proton Pump Inhibitors and Antihistamines will be March 2, 2004. Letters to physicians / prescribers regarding their patients currently on PPI's and antihistamines have been mailed. Physicians / prescribers must reply to these letters to ensure their patients are 'grand fathered' in and can continue to receive their current medication without prior authorization.

The prior authorization form will be available on the DHS website before the implementation date (www.state.nd.us/eforms).

Following are the criteria:

Proton Pump Inhibitors (PPI's)

Prilosec OTC does not require prior authorization (PA) -- it is covered by ND Medicaid.

All others require PA (Net cost to Medicaid: Prilosec OTC <<< Protonix < Aciphex < Prevacid < omeprazole << Nexium < Prilosec).

No PA required if patient is 0-12 years of age.

Coverage will be authorized through PA if one of the following has been met:

- The patient has failed a 14-day trial of OTC Prilosec
- Prilosec OTC has caused an adverse reaction or is contraindicated
- Patient is pregnant
- Patient is unable to take tablets

Antihistamines

Loratadine OTC does not require prior authorization (PA) -- it is covered by ND Medicaid. All others require PA. No PA required if patient is 0-12 years of age.

Coverage will be authorized through PA if one of the following has been met:

- The patient has failed a 14-day trial of OTC loratadine
- Loratadine OTC has caused an adverse reaction or is contraindicated
- The patient has a diagnosis of Urticaria

New Service Limits Tracking

Providers and recipients have been inquiring as to how the number of services used will be tracked for the new limits.

Medicaid's claims processing system is 26 years old and does not have the capability to alert the provider or recipient when they are approaching the new limits.

Generally, services subject to the limits will be provided through a single source and the provider should keep a record of the number of services delivered. Recipients are also responsible for keeping a record of number of services utilized in a calendar year.

When the limit is reached, any additional claims for those services will be denied. A provider can send in the prior authorization form for a retroactive review and consideration for approval. If the review team determines the service was medically necessary, the additional visit may be approved. If the Department does not approve the service, the recipient may be billed.

The prior authorization process should be used if a provider is aware that the limit is going to be reached and there is still a medical need for additional services. The prior authorization form and process are described on pages 8 and 9 of this newsletter.

Attention Physicians

Prilosec OTC and Claritin OTC are covered by North Dakota Medicaid, however, you must write a prescription for these OTC drugs.

E-form for Hysterectomies

The Physician Certification for Hysterectomies is available on e-forms. The form number is 614.

North Dakota Department of Human Services
Medical Services Division

Clarifications on Service Limits and Co-Pays

The effective date for the new co-pays has been extended to January 1, 2004, with the EXCEPTION of the $1 lab and x-ray co-pays, which are being postponed until April 1, 2004.

The effective date for the new limits is January 1, 2004, with the EXCEPTION of the 12 per year office visit limit, which is being postponed until April 1, 2004. Additional information will be provided prior to the implementation of this limit. ALL OTHER limits are effective January 1, 2004.

1. How do the limits and copays affect children?

Co-pays do not apply to children. Limits on services, other than those noted, do apply to children.

2. Will the service limits and new co-payments have any affect on Home and Community Based (HCBS) clients?

Yes, the limits and co-pays apply to Home and Community Based clients, when they seek services that have a limit or co-pay imposed.

3. Will the service limits and new co-payments apply to recipients receiving Home Health Services?

Yes, the limits and co-pays apply to recipients receiving Home Health Services, when they seek services that have a limit or co-pay imposed.

4. Co-pays do not apply to persons in institutions. What is an institution?

Institutions include Nursing Homes , Swing Beds, ICF/MRs, and the State Hospital. Basic Care is NOT an institutional service. Co-pays do apply to Basic Care Residents, when they seek services that have a co-pay imposed.

5. What is the co-pay amount for psychiatrists?

$2.00 per visit. This is the co-pay for office visits, which is not a new co-pay.

6. What is the age limit for children that are exempt from co-pays?

Up to 21 years of age.

7. Will the state be developing an online referral/authorization system so that we could do this faster, etc.?

At this time, we are not planning an on-line system. We are developing a prototype form, which is available at www.discovernd.com Go to Government and under state forms it will be form #481. This can be completed on-line, printed and faxed to 701-328-1544. Medical Services staff will review the request and fax the decision back to the provider.

8. If a recipient receives a medical authorization, are all visits for this diagnosis covered, or is an authorization needed each time the patient comes to the clinic?

Cases will be handled on an individual basis, which may include authorizations for an extended period of time.

9. Who is responsible for requesting the prior authorization? Patient or Provider?

The Provider. They should submit a prior or retro request for the services.

10. How do we appeal the denial for the request of additional services?

Appeal Process information will accompany each denial response. Providers may not appeal, only recipients have appeal rights.

11. Do the limits apply to foster care children?

Yes. The limits apply to all Medicaid recipients.

12. Are therapies provided through school-based programs included in the limits?

No. Therapies provided through school-based services are excluded from the limits.

13. How long does the prior authorization process take?

We are planning for the turn around time to be 5 business days.

14. Do the limits apply to children who are enrolled in Infant and Family Services or Early Intervention Children?

Yes. The limits apply to all Medicaid recipients.

15. Do the limits apply to children who have other insurance and are using Medicaid as a secondary insurance?

Yes, regardless of other insurance, the limits are based on the number of services, not the amount Medicaid reimburses.

16. Have recipients been notified of all the changes?

Recipients received a newsletter in August. The newsletter contained the same information as the September Provider Bulletin.

17. Are there any legal restrictions on the refusal to serve ND Medical Assistance Patients?

The Provider Agreement acknowledges the provider will serve Medical Assistance recipients. If the services are provided to Medicaid recipients, the provider needs to bill for the services.

18. If the recipient exceeds any of the service limits with no prior approval, who will be liable, the provider or recipient?

The recipient.

19. Will all the different co pays be listed on the Medifax printout?

No, the magnitude of the changes that would need to be made and the expense to do so, make this cost prohibitive.

20. Do recipient co-pays count toward the Recipient Liability?

Yes. Recipients will need to collect a receipt from the provider when a co-payment is made. The recipient will submit all receipts to their county eligibility worker and the worker can reduce the Recipient Liability.

21. Does Medicaid require a co-payment on patients that have insurance primary to Medicaid?

Yes. If Medicaid pays any dollar amount after a primary payer has paid, the Medicaid co-payment is required.

22. If a provider bills the professional portion of an MRI through the clinic and the technical portion is billed through the hospital, is there one co-payment or two?

One co-payment, on the technical portion.

23. Are recipients who are also on Medicare exempt from co-payments?

No. The co-payments apply to Medicare/Medicaid dually eligible recipients. (Please note exceptions for persons in institutions.)

24. What telephone number can providers or recipients use to contact someone with additional questions?

Providers can call 701-328-2321. Based on the question, the secretary will transfer the call to the appropriate staff member.

NORTH DAKOTA MEDICAL ASSISTANCE
COPAYMENTS, COPAYMENT EXEMPTION, AND SERVICE LIMITS,
January 2004

COPAYMENTS	PERSONS EXEMPT FROM COPAYMENTS	SERVICE LIMITS
• $1 for spinal manipulation received during a chiropractic appointment • $1 for each outpatient speech therapy visit • $2 for each office visit. This includes <u>all</u> Medical Doctors, Nurse Practitioners, and Physician Assistant Certified. • $2 for each dental clinic appointment • $2 for each outpatient physical therapy visit • $2 for each outpatient occupational therapy visit • $2 for each optometry appointment • $2 for each outpatient psychological appointment • $2 for each outpatient hearing test visit • $3 for each hearing aid supplied • $3 for each clinic appointment to a Rural Health Clinic or Federally Qualified Health Center • $3 for each podiatry office appointment • $3 Prescription Drugs - Brand Name drugs • $6 for each emergency room visit that is not an emergency • $75 for each inpatient hospital stay	• Individuals under age 21 • Individuals who are pregnant • Service is for a true emergency • Service is for Family Planning purposes • Individuals residing in institutions such as: - Nursing Home/Long Term Care - Swing Bed/Long Term Care - Intermediate Care Facility/MR - State Hospital - State Hospital<21/JCAHO Facility - Anne Carlsen Home	• Chiropractic manipulation visits - 12 per year • Chiropractic x-rays - 2 per year • Occupational Therapy Evaluation - 1 per year • Occupational therapy - 20 visits per year; (applies to services delivered in a clinic or outpatient hospital setting. This limit does not apply to school-based services for children.) • Psychological Evaluation - 1 per year • Psychological therapy visits - 40 per year • Psychological testing - four units (hours) per year • Speech therapy visits - 30 per year; (applies to services delivered in a clinic or outpatient hospital setting. This limit does not apply to school-based services for children.) • Speech evaluation - one per year • Physical therapy evaluation - 1 per year • Physical therapy visits - 15 per year; (applies to services delivered in a clinic or outpatient hospital setting. This limit does not apply to school-based services for children.) • Eyeglasses for Individuals 21 and older - once every 3 years. • Eye exams for individuals 21 and older - once every 3 years **Authorizations in excess of the above limits may be granted by the Medicaid Utilization staff when medically necessary. If a recipient exceeds any of the service limits, a prior authorization is required.**